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The 2015 emergency care reform in Poland: Some improvements, some unmet demands and some looming conflicts☆

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ABSTRACT

Between 2006 and 2015, the Act on the State Emergency Medical System was the key act governing the organization, financing and provision of emergency care in Poland. From the moment it entered into force, it had been heavily criticized. The critique focused, among others, on the lack of provisions allowing for emergency medical services (EMS) to be performed outside the EMS units, the lack of a separate Act regulating the profession of a medical rescuer and the lack of a separate professional organization representing medical rescuers. As early as 2008 a team of specialists was set up to work on amending the Act and these works resulted in the draft Act on the State Emergency Medical System that was submitted to public consultations on 19 August, 2014. This draft was further reworked in 2015 and was signed by the President on 25 September of the same year. The Act addressed some of the shortcomings of the EMS legislation that was previously in place. However, the new Act did not meet the key demands of medical rescuers; namely, it did not introduce a separate legal act regulating this profession nor established a professional organisation representing their interests. An analysis of the vested interests of various groups of medical professionals indicates that these interests are likely to have influenced the final legislative outcome. The Act, as well as its implementing executive regulation from April 2016, may reduce support of certain medical professional groups during the Act's implementation as well as create tensions between these groups, especially between medical rescuers and nurses.

1. Introduction

This article provides a summary of changes introduced by the Act of 25 September, 2015 Amending the Act on the State Emergency Medical System, the Act on Therapeutic Activity, the Act Amending the Act on Therapeutic Activity and certain other acts (henceforth called 'the Act of 25 September, 2015' or 'the Act') and of the policy process leading to its implementation, including the positions of the various stakeholders. The new President, in office since 6 August, 2015, signed the Act before the parliamentary elections took place on 25 October, 2015. Most of the Act's provisions came into force on 1 January, 2016.

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2. Background: an overview of history and regulation of emergency care in Poland

The emergency medical system (EMS) in Poland has, like emergency medical systems in many EU member states, a relatively young history [10]. The key milestone in its development was the introduction of the government programme titled Integrated Emergency Medical System for 1999–2003. The goal of this programme was to prepare groundwork for the introduction of an integrated EMS, with common or compatible communications network, common procedures and compatible medical equipment. The 2001 Act on the State Medical Emergency System laid the legal foundation for such system but was in large part not implemented as no executive regulations implementing the Act had been actually developed [6]. This was mainly due to the lack of funds for the Act's implementation and changed reform priorities of the left-wing government elected in 2003 [2].

The introduction of the 2006 Act on the State Emergency Medical System was a direct reaction to an accident that took place in early 2006 in Katowice. The inept emergency response to a collapse of a market hall, which resulted in 65 fatal casualties, exposed the weaknesses of the existing emergency care system. Following this accident, the government made the development of a new legislation in the area of EMS its priority.

Between 2006 and 2015, the Act on the State Emergency Medical System was the key act governing the organization, financing and provision of emergency care in Poland (Box 1). The Act introduced many positive changes compared to the 2001 Act, including the introduction and regulation of the profession of a medical rescuer as a new medical profession, which included the recognition of the medical rescuers' training obtained in other EU or EFTA countries according to Directive 2002/22/EC; granting legal protection to persons providing qualified first aid or performing medical rescue activities, similar to the protection granted by the Penal Code to the publicly employed health care personnel; introduction of first aid education at all levels of education (primary, secondary, tertiary). The Act also introduced financing of EMS directly from the State Budget and not only from the means of the National Health Fund's (NHF's) as had been the case previously [3].

According to a recent report by the Supreme Control Office [7], the functioning of the EMS was on the whole satisfactory. Patients were assured quick assistance on the site of emergency, with 90% of cases having received assistance within the maximum response time, medical transport and treatment in the emergency care hospital departments (called SORs in Polish). However, the report also found a number of inefficiencies. For example, the SORs were found to treat patients that did not require emergency care, with the share of such patients accounting for 30–80% of all

Box 1: Organization of EMS in Poland.

EMS units

The EMS consists of *emergency care hospital departments* (*szpitalne oddziały ratunkowe*, SORs) and *medical emergency teams* (*zespoły ratownictwa medycznego*, ZRMs), including air medical emergency teams. SORs are accredited hospital units. They were created to fill the gap between pre-hospital care and specialist hospital care and their key role is to provide the preliminary diagnosis and stabilize the patient. SORs can be established in hospitals that have a general surgery ward, including a trauma unit; internal medicine ward or a pediatric ward (in case of children's hospitals); anesthesiology and intensive care ward; a diagnostic imaging laboratory. SORs must have 24/7 access to diagnostic tests in a diagnostic imaging laboratory; computerized CT scans and endoscopy (including gastroscopy, rectoscopy, bronchoscopy and laryngoscopy). SORs must also have a heliport on site or within 5 min reach (these requirements were to be obligatory from 1 January, 2017 but the Act of 25 September 2015 deferred this to a later date). ZRMs are usually organized as independent units in the medical emergency system, though they can also be part of the SORs. They provide emergency medical care on the site of the accident and transport the patient to the nearest SOR or the nearest trauma centre (see below). They are equipped with sanitary transport vehicles (ambulances) and have constant radio contact with the Emergency Notification Centre (*Centrum Powiadamiania Ratunkowego*, CPR). There are two types of ZRMs: a basic emergency team (P-type) consists of a nurse and/or a medical rescuer; a specialized emergency team (S-type) must additionally include a medical physician. Both the SORs and the ZRMs must conclude contracts with the NHF in order to be included in the EMS. In 2015, there were 216 SORs and 1460 ZRMs (including seasonal ones) (Ministry of Health [5]).

Units and systems cooperating with the EMS

The following units and systems cooperate with the EMS: *trauma centres* (*centra urazowe*, CUs) (established since 2009); *hospital departments specialized in the provision of services vital for medical rescue* that have been included in the voievodeship medical emergency plans; and various *rescue systems* (e.g. fire-brigade, police)—rescuers working in these systems are authorized to provide the so-called qualified first aid services. The CUs are functionally independent hospital units. They combine various hospital departments. They were established to provide complex diagnostics and treatment to patients suffering from multiple injuries affecting more than one organ. They collaborate with the SORs. CUs cover populations of no less than 1 million inhabitants who reside within a 1.5 h reach radius. They must have access to heliports. After treatment in a CU, the patient is moved to another hospital department or to another health care facility for further treatment or rehabilitation. In 2015, there were 14 CUs (Ministry of Health [5]). The EMS is part of the National Rescue and Firefighting System (Krajowy System Ratowniczo-Gaśniczy, KSRG). A common emergency notification system was established to ensure integration of the medical emergency system and the KSRG. This system includes CPRs and Voievodeship Rescue Communication Centres (Wojewódzkie Centrum Powiadamiania Ratunkowego, WCPR).

Sources: Based on Sagan et al. [9], Ministry of Health [5], Furtak-Niczyporuk and Drop [1], Ogrodnik [8].

patients seen in the SORs. The reason for this may have been poor access to ambulatory care, especially out-of-hours and during holidays, and lack of mechanisms to restrict access to emergency care to patients who are not eligible for it, a problem also encountered in many other countries [11]. Moreover, trauma centres treated all trauma patients, including patients that did not qualify for treatment in such centres; and medical emergency teams were often sent to patients who did not experience a sudden threat to health (up to 30% of cases). The number of doctors, nurses, medical rescuers, dispatchers was also not always sufficient and incompletely staffed medical emergency teams were sometimes sent to emergency cases, especially out-of-hours and during holidays. To address staff shortages, doctors worked extra hours under civil law contracts—this in many cases meant excessive workload and could potentially endanger the health and safety of patients [1].

Despite the many improvements that the 2006 Act introduced, it was heavily criticized from the moment it entered into force. Criticized were, among others, the lack of provisions allowing for emergency medical services to be performed outside the EMS units (i.e. emergency care hospital departments and medical emergency teams); the lack of provisions on keeping records on the number of medical rescuers in the system; the lack of a separate Act regulating the profession of a medical rescuer and the lack of a separate professional organization representing medical rescuers [8].

In the light of the above arguments, as early as 2008 a team of specialists was set up to work on amending the Act [8]. These works resulted in the draft Act on the State Emergency Medical System that was submitted to public consultations on 19 August, 2014.

3. Content of health policy

The key changes included in the proposal are summarised in Table 1. The proposal addressed some of the shortcomings of the 2006 Act. For example, it allowed for medical services to be performed outside the units of the EMS and standardized education of medical rescuers. However, instead of proposing a separate legal act to regulate the profession of the medical rescuer, the proposal contained, in itself, a complex regulation of the profession. This meant that there is still some potential for conflicts with other legal acts, e.g. with regards to the rights and duties of medical rescuers, accountability frameworks, etc. The establishment of a professional organization for medical rescuers (a professional self-government) was also not included in the proposal. The Ministry claimed that this solution was chosen because the two leading organizations that could potentially take leadership in the creation of such self-government, the Polish Association of Medical Rescuers based in Łódź and the State Association of Medical Rescuers based in Katowice, could not find common ground with regards to the goals for the profession. However, this was more of an excuse rather than the real reason. The Ministry was probably cautious not to antagonize doctors and nurses who were against the strengthening of medical rescuers as a group of medical professionals. Nurses, in particular, felt that this could threaten their position in the health system, especially given that the draft Act allowed medical rescuers to work in hospital wards (other than emergency care hospital departments) alongside nurses. The lack of professional self-government means that medical rescuers is one of the few groups of medical professionals that does not have such self-government—all other key medical professions are regulated in separate legal acts and have professional organizations that represent their interests and have disciplinary authority over them. It also means that the supervision of education, professional development and the exercise of the profession of medical rescuer will be exerted by different actors and bodies, including the Prime Minister, the Minister of Health, the Centre for Medical Education, managers of health care units, and not by the representatives of the medical rescuers themselves.

4. Policy process and key stakeholder positions

The policy idea came from the Ministry of Health and the deputies from the governing coalition parties—PO (Civic Platform) and PSL (Polish Peasant Party). Improving the EMS was declared, next to the introduction of the so-called oncology package (see www.hspm.org) as one of the priorities by the Minister of Health who was in office between November 2011 and June 2015. The drafting of a new Act on EMS was added to the work programme of the Government on 14 February, 2014. The body responsible for the development of the draft and its submission was the Minister of Health. The draft was submitted to public consultations on 19 August and one month was given for receiving comments. Over 30 public comments have been posted on the government's website. No official responses to the comments were made publicly available. A conference aimed at reconciling the draft with the comments received during the consultation process took place in December 2014. The Polish Council of Medical Rescuers and a number of other organizations voiced objections towards the proposal. Further public consultations were scheduled for January 2015. However, no such consultations were held [4]. After the presidential elections in May 2015, a new draft was proposed on 1 September and opened to public consultations on 11 September. The consultation process ended on 22 September and three days later, on 25 September, the Act was signed by the President.

Positions of the key stakeholders during the policy process are summarised below. The role of the media in stimulating the influence of the main stakeholders was negligible. Their involvement was constrained to reporting news about irregularities in the functioning of the emergency care hospital departments (e.g. events such as a patient being refused care and suffering a major loss of health or death as a result). In general, Polish media seems to be poorly oriented and involved in health policy issues that require a deeper understanding of the health care system. The role of medical professions (medical rescuers, physicians and nurses) was also quite weak during the policy process and is quite typical of health care legislation in Poland in general—health care professionals are usually not involved in drafting legal acts nor properly consulted. Public consultations are merely a formal requirement in

Table 1
Key changes introduced by the draft submitted to public consultations on 19 August, 2014 and the final version of the draft signed on 25 September, 2015.

	Draft submitted to public consultations on 19 August, 2014[a]	Act signed on 25 September, 2015[b]
Regulation of the profession of medical rescuer	– Regulates the profession of medical rescuer but unlike other medical professions, the profession of medical rescuer is not regulated in a separate legal Act	
	– Does *not* regulate the professional status of medical rescuers employed in public units outside the EMS, such as the Polish Army, the Prison Service, the Fire Brigade	– Allows medical rescuers to perform their professional tasks in public units outside the EMS
	– Does *not* regulate the standards of conduct for medical emergency teams (ZRMs) justifying this by the existence of teaching standards (but these were repealed in 2011)	– Standards of conduct for ZRMs to be regulated in a separate ordinance of the Minister of Health
	– Does *not* clarify the grey area of competence overlap between the EMS, primary care and specialist medical care provided at night and during holidays	
Professional organization of medical rescuers	– Does *not* foresee the establishment of a professional organization for medical rescuers and instead bestows the supervision over medical rescue activities onto the voievodes	
Performing emergency medical services outside the units of the EMS	– Allows for performance of emergency medical services outside the units of the EMS; however, the scope of 'medical services' is yet to be defined by the Minister of Health (not clear whether the scope of services would correspond to the scope of activities performed by medical rescuers)	– Allows medical rescuers to provide medical services, including emergency medical services, alone or under the supervision of a medical doctor, outside the units of the EMS, for example, in hospital wards other than emergency care hospital departments (SORs), within mountain rescue units, etc. (the scope of such services was to be specified in an executive regulation of the Minister of Health[c])
	– Allows ZRMs to perform lifesaving medical rescue activities only in non-hospital settings	
Education and training of medical rescuers	– All medical rescuers are to be educated at the university level (Bachelor's degree); abolishment of 2-year vocational studies; professional titles obtained to date are to be upheld (but there will be no bridging studies to compensate for the differences in the teaching programmes)	
	– Introduction of a mandatory 6-month internship after passing the final undergraduate exam	
	– Introduction of the State Exam for Medical Rescuers; students who pass this exam will be granted the right to practice by the voievodes and enter into registers of medical rescuers maintained by the Minister of Health	
	– Supervision over professional development of medical rescuers is bestowed onto the providers of professional development services (and not a professional organization)	

[a] Based on Ogrodnik [8].
[b] Based on the Act of 25 September 2015 Amending the Act on the State Emergency Medical System, the Act on Therapeutic Activity, the Act Amending the Act on Therapeutic Activity and certain other acts.
[c] Such regulation was issued on 20 April, 2016 (see Section 5).

the policy process that has to be ticked off and not seen as a way to achieve a constructive, consensual solution that would secure stakeholders' support in the implementation process.

4.1. Medical rescuers

The key objection of the medical rescuers to the 2014 and 2015 drafts was the lack of provisions establishing a professional organization representing their interests. Medical rescuers and physiotherapists are the only medical professions in the health system that have no such organization—physicians and dentists, nurses and midwives, pharmacists, and laboratory diagnosticians are associated in separate professional chambers. This deprives medical rescuers of having a real impact on shaping the rapidly changing EMS system and protecting their interests.

With regards to the 2014 draft, medical rescuers were concerned with the scope of emergency medical activities to be performed outside the units of the EMS, which, albeit at the time not yet clarified, seemed to be restricted to non-hospital settings, which they deemed as too narrow and not justified on medical grounds and also as limiting their employment opportunities. The draft also did not regulate the professional status of medical rescuers employed outside the EMS. As problematic was also seen the introduction of e-consultations because medical rescuers who made treatment decisions based on e-consultations would be deprived of the legal protection they have while performing other medical interventions. For example, when they base their decisions on the decision of a medical doctor, it is the doctor who bears the ultimate responsibility. The 2015 Act addressed some of these concerns. For example, it recognized the medical status of medical rescuers employed outside the EMS, for example, in hospital wards other than emergency care hospital departments (SORs), within mountain rescue units, etc., and allowed them to perform the same professional tasks as medical rescuers employed within the EMS. The issue of e-consultations has not been clarified.

4.2. Physicians

Physicians were not in favour of the 2014 proposal. According to the Main Chamber of Physicians the main weakness of the proposal was allowing for the existence of a variety of hospitals departments involved in the pro-

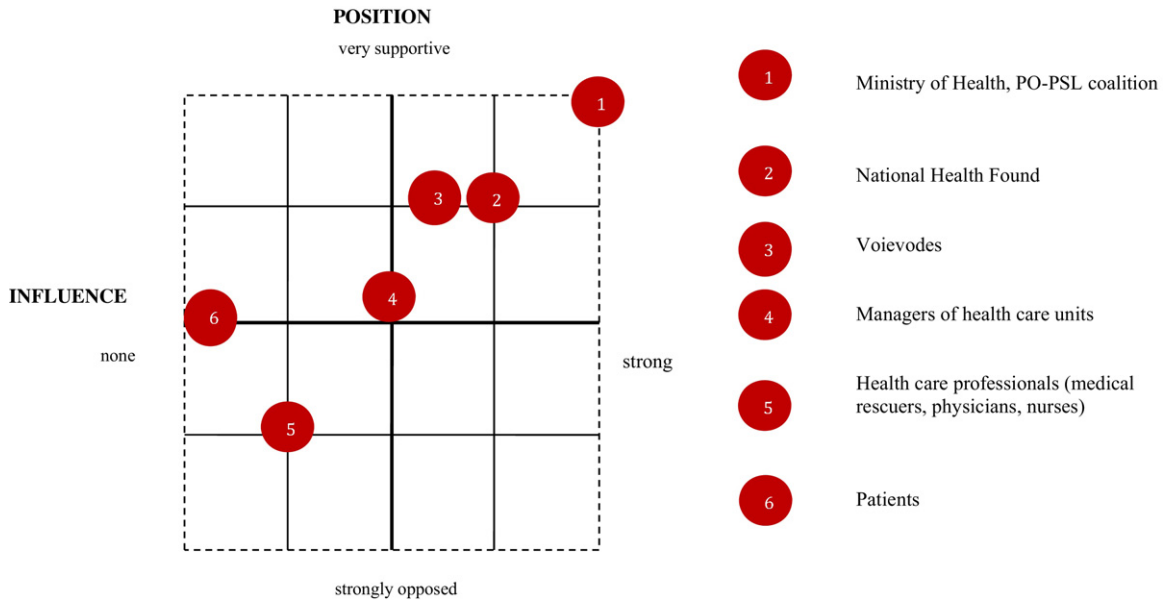

Fig. 1. Positions of key stakeholders and their influence.

Source: Authors.

vision of emergency care (such as cardiology, neurology, neurosurgery) and the lack of provisions specifying competencies of these units and cooperation between them (and between the ZRMs) in case of emergency interventions. These concerns were not addressed in the 2015 Act. However, the Act did not allow for the establishment of a self-government of medical rescuers, which was seen to be protecting physicians' interests.

4.3. Nurses

Nurses were concerned, both in 2014 and 2015, that allowing medical rescuers to perform their professional tasks outside the EMS, for example outside hospital emergency departments, may infringe upon their competencies and tasks. They feared that their position could be undermined by medical rescuers and could lead to conflicts and potentially also to attempts, by medical rescuers, to formally subordinate nurses in settings where both medical rescuers and nurses work. They also feared that some nursing jobs would be filled by medical rescuers, given the shortages of nurses in Poland. The 2015 Act also did not allow for the establishment of a self-government of medical rescuers, which was in the interest of nurses as it weakened the position of medical rescuers vis-à-vis nurses.

4.4. Other stakeholders

Other stakeholders were not strongly opposed or strongly in favour of the 2014 and 2015 drafts. From the perspective of the managers of health care units, the drafts did not constitute a major change compared to the 2006 Act.

Positions of the key stakeholders are depicted in Fig. 1.

5. Conclusions

The introduced solutions are clearly a step forward in many areas of EMS, especially in the area of education of medical rescuers (the 2015 Act standardizes it) and provision of emergency medical services (the Act enabled provision of such services outside the EMS and the use of e-consultations, although, as explained, the latter has some serious shortcomings). However, further changes are needed in order to achieve a well-functioning EMS.

The Act fails to address the demands of medical rescuers with regards to the establishment of a professional self-government representing their interests. It maintains the supervision of this profession, including in disciplinary and ethical matters, in the hands of the voievodes. Medical rescuers are therefore, next to physiotherapists, the only group of key medical professionals without their own self-government. Full support of this professional group in the implementation of the Act may therefore not be warranted.

The Act fails to address the issue of competence overlap between emergency care, primary care and specialized ambulatory care, especially out-of-hours and during holidays, and does not increase EMS financing, which means that the problem of improper use of emergency care (see Section 2) is likely to continue. It may also mean that physicians, who were concerned about the lack of clarity about competencies of various hospital units involved in the provision of emergency care and their cooperation with emergency care teams may not be very supportive when it comes to the implementation of the Act.

The Act also does not clarify the cooperation between the EMS and other emergency services (police, fire brigade), that are subordinated to ministries other than the Ministry of Health. This could mean different financing sources for different emergency services, prolonged decision-making,

and lack of unified standards and procedures. These could in turn lead to the lack of or poor coordination of activities in case of incidents requiring a coordinated response.

On 20 April, 2016, the Minister of Health issued an executive regulation on medical rescue services and other health care services that can be provided by medical rescuers. Before the executive regulation was issued, medical rescuers were being employed at hospital wards without having the scope of their competencies precisely defined and most of the time their competencies did not go beyond those of paramedics. This placed them below nurses in the hierarchical order of medical professionals in hospitals. The executive regulation has changed this. It gave medical rescuers formal competencies similar to those of nurses. This may potentially lead to conflicts between these two groups, especially since it appears that medical rescuers consider that they are better qualified than nurses (considering their role to be more medical compared to nursing) and try to put nurses in a subordinate position. At the time of writing (June 2016) it was too early to predict the effects of this executive regulation on the relationship between these two groups and on the implementation of the new Act.

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